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SUBJECT
Adult Residential Care Calculation (DPHHS-SLTC-132) Instructions

PURPOSE

This form is used by the Case Management Team (CMT) to calculate the daily rate for Assisted Living and Foster Home settings under the Residential Habilitation (RH) service.

DISTRIBUTION

The CMT completes the form with the consumer and provider to determine the rate. The providers must sign the form acknowledging they approve the rate and keep the yellow copy for their records.

INSTRUCTIONS

Consumer Name--Enter the name of the consumer.

Medicaid Number--Enter the consumer's Medicaid number.

Facility Name--List the name of the adult residential care facility.

ALF, AFH--Check the type of facility being used:

ALF – Assisted Living Facility

AFH - Adult Foster Home

A Bed, B Bed**,** C-Bed--Check the type of bed being used.

(A) Room & Board—Enter the amount the consumer pays to the facility. This amount is established by DPHHS. See chart in 899-9, page 6.

(B) Service Package—The basic service amount is established by DPHHS. See chart in 899-9, page 6.
The basic service package includes:

1. Meal service (shopping, preparation cooking and clean up);
2. Heavy housekeeping weekly (includes flat laundry);
3. Socialization and recreation;
4. Emergency Response System;
5. Scheduling Transportation; and
6. 24-hour availability of staff for safety & supervision

(C) Support Services--Those services provided by the facility in excess of the basic services. Assess the consumer's needs and rate the impairment level in conjunction with the supports the

facility will provide. For example, a consumer may be totally dependent in medication management; but if the facility only provides minimal assistance in medication management, the consumer should receive a score of 1 in that category.

0 = Independent--No impairment. The individual is able to complete the activity without difficulty and has no need for assistance. Need is met with adaptive equipment or service animal. The need is met by family or other supports. If the need is met or the facility does not provide the service, enter 0.

The facility must actually provide the service in order to receive points as listed below.

1 = Minimal Supervision--Mild impairment. The individual is able to complete the activity, but requires standby assist, cuing, prompting, or set up help.

2 = Direct Assist--Moderate impairment. The individual is able to moderately participate in the activity, but requires assistance to complete the task.

3 = Extensive Assist--Severe impairment. The individual is able to minimally participate in the activity, but requires extensive assistance to complete the task.

4 = Total Dependence--Total impairment. The individual is not able to participate in the activity and requires total assistance for the task to be completed.

Bathing = Assistance with sponge, bed, tub or shower bathing, with or without assistive devices.

Personal Hygiene = Assistance with routine hair care, oral care, shaving, washing hands and face.

Dressing = Assistance selecting, putting on, and taking off clothes, adaptive, prosthetic or assistive devices.

Toileting = Assistance getting to the bathroom, managing clothing, diapers, catheter, colostomy bag, or cleaning self.

Medication Management = Assistance with reminders, opening containers, obtaining refills, supplies and equipment.

Medical Management = Assistance with scheduling and/or accompanying to medical appointments, obtaining medical information form health care professional, monitoring compliance.

Transfers = Assistance getting in and out of bed, chair, vehicle. Assistance in positioning themselves in bed, chair or vehicle. (This does not include tub and toilet, which are scored in bathing and toileting support services).

Mobility = Assistance with ambulation inside, outside, on uneven surfaces with or without assistive devices.

Diet = Assistance with preparation or following a medically prescribed diet.

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Eating = Assistance with feeding self, pour liquids, cut, chew, swallow with or without assistive devices.

Exercise = Assistance with routine medically prescribed exercise.

Housekeeping = Assistance with laundry, bedding that needs to be changed more than 1 time a week, room cleaning that needs to be done more than 1 time a week.

Socialization = Assistance with one on one socialization, assistance to and from activities (this does not include ambulation assist which is scored in the ambulation support service).

Communication = Assistance with speech, hearing, visual, or language with or without assistive devices.

Behavior Management = Assistance with wandering, combativeness, or other inappropriate actions.

Impaired Judgment = Assistance with decision-making.

Memory Cueing = Assistance with cognitive deficits, frequency of reminders of daily living activities with or without assistive devices. (Example; assisting individual with making and using a memory book.)

Time Management = Assistance with scheduling/ reminding of non-medical activities. (This differs from socialization in that the individual requires help in managing their time.)

Money Management = Assistance with budgeting and/or paying bills.

Transportation = Assistance with accessing non-medical transportation.

Other = Assistance with other support services not described above.

REMINDER

The residential care provider is responsible for the following in the service package and no points may be assigned on the rate calculation form for these basic services:

Meal Preparation: Nutritious menu planning, shopping for food, preparation and serving of 3 meals and 2 snacks a day, set up and clean up of the meal and snacks.

Homemaking: One time a week general room cleaning, laundering bedding 1 time a week and general upkeep of the building.

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Medication Oversight: Medication stored in a separate, safe and secure area and oversight (to the extent permitted under state Law).

Social and Recreation: Common areas made available and opportunities for socialization and recreation time daily.

Supervision: 24-hour on-site response staff to meet scheduled or unpredictable needs and to provide supervision of safety and security.

Medical Transportation: Arrange for medical transportation as needed.

Calculate the support services score by adding up the total score.

Multiply the score by cost per unit (see page 6 for current multiplier) and write the product in the box.

(D) (A+B+C)--List the total by adding the following:
- (A) Room & Board
- (B) Service Package
- (C) Support Services Total

(E) Enter the facility's private pay rate.

(F) Total to facility is the lesser of D or E but no more than the maximum Medicaid payment (This line may not exceed the maximum Medicaid daily rate x 30 plus current room and board rate). See chart in 899-9, page 6 for current maximum rate.

The following outlines the responsibility of payment to the facility:

Effective Date--Enter the date on which this rate is effective.

Daily Rate Computation

(A1) Enter the room and board amount

(A2) Enter the current SSI recipient service contribution.

Not all consumers will have an amount entered here. It will either be applicable for consumers receiving SSI, or consumers receiving SSI/SSDI, depending on current SSI levels and/or current medically needy levels. Please see chart in 899-9, page 8 to determine which consumers are currently responsible for this payment and what amount to enter.

(A3) Enter the SSI State Supplement payment amount.

Not all consumers will have an amount entered here. It is applicable for consumers who receive any SSI and live in an ALF or AFH.

ALF=$94.00
AFH=$52.75

Reminder: A recipient in a "B" or "C" bed does not qualify for state supplement.

(G) Enter the subtotal consumer responsibility. (A1 + A2 + A3)

(H) Daily Rate--Compute F minus G and divide by 30. Enter this amount as the daily rate.

(I) Incurment and VA AA Section

(A4) AR Services used to meet Incurment. Enter the amount of Adult Residential services to be used to meet the incurment, if applicable. (HINT: Contact OPA to verify the amount of incurment available. Use a number that will be evenly divisible by the daily rate.) Divide the incurment amount by the daily rate (line H). Enter the day the Incurment is met.

(A5) VA AA - Enter the amount of VA Aid and Attendance to be used for Adult Residential services, if applicable. For VA Aid and Attendance cases add A5 to the amount in A4 and divide by the daily rate. Enter the approximate day the Incurment/VA AA is met. See pages 6 & 7 for additional VA AA instruction.

Note: OPA is responsible to contact the consumer/representative and the facility to determine the exact amount the consumer owes to the facility and how much the facility can bill. Provider's and consumers receive a Provider Information Memo (DPHHS-HCS-454) each month from OPA for eligibility spans. Providers may also use the Montana Access to Health Web Portal to verify eligibility spans.

(J) Consumer responsibility: Enter the total by adding lines G + A4 + A5

(K) Medicaid Responsibility: For consumers using services to meet an incurment, enter the day the provider begins billing the daily rate. This will be the day after the date entered in (A4) or (A5). For all other consumers enter day 1.

Provider Signature--Provider must sign and date the form.

CMT Signature--Case manager must sign and date the form.

State Supplement

Following are some scenarios that may occur with state supplement payments:

The CMT has just been notified the consumer has been receiving state supplement but it is not included in the SLTC-132. Recalculate the SLTC-132 including the state supplement amount and make the effective date the first day of the following month. **DO NOT** make the date retroactive.

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A consumer has been residing in a facility for some time and the SLTC-132 does not include the state supplement amount. The CMT realizes the consumer qualifies for state supplement. The CMT recalculates a new SLTC-132 including the state supplement and makes the effective date the first day of the following month. **DO NOT** make the date retroactive.

Veteran's Aid and Attendance

Medically Needy HCBS consumers who receive VA A & A will have two financial obligations to meet each month in order to be Medicaid eligible. The most important difference for the VA/Med Needy consumer is that the cash option may not be utilized in establishing Medicaid eligibility. The eligibility must be determined by incurring medical expenses equal to the monthly VA A & A payment, plus the incurment amount established by OPA. Medical expenses recognized by the VA must total the VA payment and must be incurred in the present month. Medical expenses recognized by the VA include the following:

- Cost for assisted living
- Cost for home care attendants
- Premiums for private medical insurance, Medicare and Medigap insurance,
- Incontinence care supplies (adult diapers and pads only)
- Diabetic testing supplies, insulin and syringes
- Prescription co-pays

Services not recognized by the VA may be used to help meet the Medicaid incurment portion of the consumer responsibility and these services may be incurred in the prior month. The primary service that will be used in this manner will be the **case management fee**.

As a result of the requirement that most medical expenses must be incurred in the present month, the consumer will not be eligible for Medicaid each month until the total VA/incurment obligation has been met. OPA, upon receiving verification of incurred medical expenses (see example below) will determine the day the consumer becomes Medicaid eligible. The consumer and the provider will be notified of this determination via the Provider Informational Memo (DPHHS-HCS-454). The consumer may be eligible for a portion of one day and then fully eligible for all succeeding days until the end of the month. This memo will specify the consumer's responsibility on the partial day and will state that the balance of that day's charge will be billable to Medicaid by the provider. It will also document the dates of Medicaid eligibility for the rest of the month.

OPA is not able to determine eligibility for the present month until verification of all incurred bills is received (bill from AR provider, pharmacy co-pays, etc.). Therefore, it is important that case managers stress to consumers and providers the importance of submitting bills as soon as possible after they are incurred.

Provider Charges and Bills

In order for OPA to use the facility charges toward the consumer's incurment the provider bill must contain the following;

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1. Facility Name
2. Name of consumer
3. The service provided – Adult Residential Services
4. Number of days incurred
5. Amount of cost per day and the total cost

Example;

Happy Acres Assisted Living Facility – Bozeman, MT 59715
Consumer: James Driggers
From January 1, 2013-January 7th 2013, you have incurred 7 days of Adult Residential Services @ $62.12 per day for a total of $ 428.61.

From this example the SLTC-131 submitted to OPA should be completed as follows;

Services used for Incurment						Ser
Start Date	Service	Provider	Provider Number	Units	Cost Per Unit	Amount applied to monthly incurment
1/1/13	Adult Residential services	Happy Acres	12345678	7	61.23	$ Not to exceed 428.61

Have the provider submit the bill after the date the consumer's incurment is met. Providers may submit the bill prior, but the consumer's case will usually be processed after the date the incurment has been met.

Note – The provider must not include "room and board" costs on the bill submitted to OPA.

Case Management and VA Aid & Attendance

In rare cases, a consumer receiving VA &A may not have an incurment (e.g. spousal impoverishment cases where the majority income goes to the non-waiver spouse). In these instances, the CMT is unable to bill for Case Management fees for the days of the month that the consumer is not Medicaid eligible and consumers are then responsible to privately pay for case management (e.g. consumer is eligible for Medicaid on day 7. Days 1-6 are private pay).

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ADULT RESIDENTIAL CALCULATION HISTORY (From January 2006)

Use this chart to obtain the appropriate and current figures required when completing the Adult Residential Care Calculation form, SLTC-132.

Effective Date	Room & Board	Service Package	Contribution To Services	Maximum Medicaid Daily Rate Upper Limit	Maximum Total to Facility Line F	LOC Score Multiplier
1/1/06	$445	$658	SSI Recipients - $58	$61.80	$2,299.00	
1/1/07	$445	$678	SSI Recipients - $78	$61.80	$2,299.00	
8/1/07	$495	$652	SSI Recipients- $28	$63.35	$2,395.50	
1/1/08	$495	$666	SSI Recipients - $42	$63.35	$2,395.50	
8/1/08	$537	$717	SS/SSDI Recipients- $8	$65.05	$2,488.50	
1/1/09	$545	$717	SSI Recipients-- $29	$65.05	$2496.50	34.00
7/1/09	$545	$877	SSI Recipients $29	$70.38	$2656.40	34.00
7/1/10	$545	$916	SSI Recipients-- $29	$71.67	$2695.10	34.00
9/1/2011	$545	$885	SSI Recipients - - $29	$70.65	$2664.50	34.00
1/1/2012	$545	$885	SSI Recipients – $53	$70.65	$2664.50	34.00
1/1/2013	$545	$885	SSI Recipients – $65	$70.65	$2664.50	34.00

***Please remember that even if the consumer is at the maximum rate, the maximum will not appear in the daily rate box. However, when you figure in the extras such as State Supplement, VA A & A, Line (A2), contribution to services, etc., the provider will be receiving the maximum.